GROUP MEDICAL PLANS

FOR ACTIVE AND RETIRED EMPLOYEES

CIGNA Open Access Plus
CIGNA Network POS
HMO Illinois
Blue Advantage

INTRODUCTION

One of the major policies of Universities Research Association, Inc. and Fermi National Accelerator Laboratory is to provide a comprehensive program of benefits for its employees. Included in the benefit program are four medical plans, Cigna Open Access Plus, Cigna Network POS, Blue Cross HMO Illinois and Blue Cross Blue Advantage HMO. Each of the plans provides valuable protection for you and your family against the steadily rising costs of medical care. You should elect the plan that best meets your needs.

The Connecticut General CIGNA Open Access Plus Plan is designed to integrate two types of medical plan designs in one. It is designed to include features found in the traditional indemnity medical insurance plan and the features found in a managed care plan. When you need medical care, you can use this plan in the way that fits you best. You can go "in-network" and visit a participating provider at a cost savings, or you can go "out-of-network" and use any provider of your choice, but your cost will be more.

The Health Maintenance Organizations are designed to provide full coverage for most expenses when you are sick or injured and also cover routine and preventive care. When you join an HMO plan, you must select a primary care doctor under contract with that HMO, and almost all referrals to specialists and hospitals are arranged through the primary care doctor. Most services are paid in full, and the lifetime maximum benefit for you and each of your covered dependents is unlimited.

This booklet provides a summary of your benefits under the Universities Research Association Medical Plan. It is the official Summary Plan Description. The actual payment of benefits and the administration of the plan is covered by the official plan document which may be amended from time to time. In the event of any conflict between this booklet and the plan document and any interpretative rules, the specific provisions of the plan document and interpretative rules will govern.

GLOSSARY OF TERMS

Coinsurance: a portion of the cost for certain medical care services, over and above the deductible you pay. You and the plan share responsibility for paying this cost, with the plan paying a specified percentage of this cost and you paying the balance. For example a plan may pay 90% of covered charges then the covered person pays 10%...

Copayment: also called copay, is a cost sharing arrangement in which a covered person pays a specified charge for a specified service, such as $15 for an office visit, and the health plan pays the balance of the charge. Typical copayments are fixed or variable flat amounts for physician office visits and prescription drugs.

Covered person: an individual who meets eligibility requirements and for whom premium payments are paid for specified benefits of the contractual agreement.

Deductible: the amount of eligible expenses a covered person must pay each calendar year from his/her own pocket before the health plan will make payment for eligible benefits.

Drug formulary: a listing of prescription medications that the health plan prefers for use and that will be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan.

Eligible Dependents: an employees eligible dependents include the employee's lawful spouse, unmarried children including step and /or legally adopted children and who are under the age of 19, or under age 23, supported by you and enrolled in school as a full time student, or any age if incapacitated.

If you are an HMO participant your eligible dependents also include children who are under your legal guardianship or who are in your custody under an interim court order prior to finalization of adoption.

Explanation of benefits (EOB): the statement sent to covered persons by their health plan listing services provided, amount billed and payment made or denied.

Generic drug: a chemically equivalent copy designed from a brand-name drug whose patent has expired. A generic is typically less expensive and sold under a common or generic name for that drug (e.g. the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam).

Medicaid: a federal program administered and operated individually by participating state and territorial governments which provides medical benefits to eligible low income persons needing health care. The federal and state governments share the program's costs.

Medicare: a nationwide, federally administered health insurance program that covers the costs of hospitalization, medical care and some related services for eligible persons.

Non-Preferred Brand drugs: non-preferred brand drugs are those which generally have generic equivalents and/or have one or more Preferred Brand options within the same drug class.

Out-of-pocket limit: the total payment toward eligible expenses that a covered person funds, (i.e. coinsurance), as defined per the contract. Once this limit is reached, benefits will increase to 100% for health services received during the rest of that calendar year. Some out-of-pocket costs (e.g. mental health, penalties of non-pre-certification, etc.) are not eligible for out-of-pocket limits.

Participating Network provider: a provider who has contracted with the health plan to deliver medical services to covered persons. The provider may be a hospital, pharmacy or other facility or physician who has contractually accepted the terms and conditions as set forth by the health plan. A participating provider is also known as being an in-network provider.

Preferred brand drug: preferred brand drugs generally do not have a generic equivalent and are either more effective than other drugs in the same class or are equally effective but less costly than the other drugs in their class.

Prior Authorization /Pre-Authorized : The term Prior Authorization means the approval that the provider must receive prior to services being rendered in order for certain services and benefits to be covered under the plan. Service that requires Prior Authorization includes, but is not limited to:

- Inpatient hospital services
- Inpatient services at any participating Other Health Care Facility
- Residential treatment
- Non emergency ambulance
- Transplant services

Utilization review: a formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.

OPEN ACCESS PLUS PLAN

The open access plan pays benefits on the basis of "reasonable and customary charges" and "medically necessary" for the diagnosis and treatment of an illness, injury or pregnancy. The following is a summary of the plan.

Your costs will be lower when you use physicians and health facilities that are in the provider network. A directory is available from the Benefits Office, but it is highly recommended that you call the **CIGNA TOLL-FREE CARE LINE AT 1-800-438-0247 or access CIGNA's website at www.cigna.com/healthcare** to get the most current information on provider network status.

Pre-admissions Certification & Continued Stay Review is required for inpatient hospitalizations. Non-emergency admissions must be pre-approved by calling the **CIGNA Toll-Free Care Line at 800-438-0247.** Emergency admissions must be reported within 24 hours of hospitalization. Failure to report the hospital stay or

remaining in the hospital beyond the medically necessary days will reduce the hospital payment by 50% up to a $1,000.00 penalty and/or the cost of not-approved days.

OPEN ACCESS PLUS PLAN SCHEDULE OF BENEFITS

	In-network	Out-of-network
Annual Calendar Year Deductible		
Individual	$250	$500
Family	$750	$1,500
	Cross accumulated	
Annual Calendar Year Out-of-Pocket Maximum (Excludes Deductible, co-payments and Ineligible Expenses)		
Individual	$1,500	$3,000
Family	$4,500	$9,000
	Cross accumulated	
Individual Lifetime Maximum Benefit		
	$2,000,000 combined in and out of network benefits	
Hospital Inpatient Benefits After Plan Deductible		
Room & Board (semi-private)	90%	80%
Ancillary Charges	90%	80%
Hospital Outpatient Benefits After Plan Deductible		
Hospital Charges	90%	80%
Physician Charges	90%	80%
Surgery Benefits After Plan Deductible		
Inpatient	90%	80%
Outpatient	90%	80%
Physician Benefits		
Hospital Visits	90%	80%
Office Visits	$15 copay 100%	80%
Chiropractor Visits	$15 copay 100%	80%
Diagnostic X-Ray & Lab Benefits		
Billed by physician's office	100%	80%
Billed by other provider	90%	80%
Newborn Benefits		
Hospital Nursery	90%	80%
Well Baby Care Doctor's office visits to age 2	$15 copay 100%	No coverage
Mental Illness Treatment		
Inpatient	90%	80%
Outpatient	$15 Copayment	80%
Maximum outpatient benefit per calendar year	35 visits	35 visits (combined)
Substance Abuse Treatment		
Inpatient	90%	80%
Outpatient	90%	80%
Maximum outpatient benefit per calendar year	30 visits	30 visits (combined)
Routine Services		
Physical exam one per calendar year after age 2	$15 copay 100% $300 max.	Not covered
Eye exams	Not covered	Not covered
Eye Glasses or Contacts	Not covered	Not covered
Hearing Exams & Aids	Not covered	Not covered
Prescription Drug Benefits		
Pharmacy (30 day supply)		
Generic Drugs	$10 copay 100%	80%
Preferred brand name drugs	$20 copay 100%	80%
Non-preferred brand name drugs	$40 copay 100%	80%
Mail order (90-day supply)		
Generic Drugs	$20 copay 100%	n/a
Preferred brand name drugs	$40 copay 100%	n/a

OPEN ACCESS PLUS PLAN SCHEDULE OF BENEFITS

	In-network	Out-of-network
Non-preferred brand name drugs	$80 copay 100%	n/a

Private rooms are limited to the semi-private negotiated room rate

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charges means the amount payable to the surgeon prior to any reductions due to deductible or coinsurance.)

Co-Surgeon

The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20% of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charges means the amount payable to the surgeon prior to any reductions due to deductible or coinsurance.)

Not all prescriptions are covered. Check with the claims office and RX Prime, the prescription card administrator.

HEALTH MAINTENANCE ORGANIZATION PLANS SCHEDULE OF BENEFITS

PRIMARY CARE PHYSICIAN MUST APPROVE TREATMENT IN ORDER FOR CHARGES TO BE COVERED AT THE FOLLOWING LEVELS.

	HMO IL / BLUE ADVANTAGE HMO	CIGNA NETWORK POS PLAN In-Network	Out-of-Network*
Hospital Inpatient Benefits			
Room & Boards (semi-private)	$250 copay, 100%	$150 copay, 100%	70%
Ancillary charges	100%	100%	70%
Hospital Outpatient Benefits			
Emergency Hospital Charges	100% You must follow the emergency procedure described in each Plan's literature. A copayment may apply.	100%	70%
Emergency Doctor Charges	100% You must follow the emergency procedure described in each Plan's literature. A copayment may apply.	100%	70%
Surgery Benefits			
Inpatient	100%	100%	70%
Outpatient	$150 copay, 100%	$75 copay, 100%	70%
Physician Benefits			
Hospital Visits	100%	100%	70%
Office Visits	$15 copay per office visit 100%	$15 copay per office visit 100%	70%
Chiropractor	May be covered with a referral		70%
Specialist	$25 copay per office visit 100% A specialist copay will not apply to the following physician specialty types: internal medicine, general practitioner, family practice, pediatrician, optometrist, mental health provider, chemical dependency provider and obstetrician/gynecologist.	$15 copay per office visit 100%	70%
Diagnostic X-Ray & Lab Benefits	100%	100%	70%
Rehabilitative Therapy	$15 copay, 100% 60 visits per year	$15 copay, 100% 60 visits per year	70%

HEALTH MAINTENANCE ORGANIZATION PLANS SCHEDULE OF BENEFITS (CONT.)

	HMO IL / BLUE ADVANTAGE HMO	CIGNA NETWORK POS PLAN In-Network	Out-of-Network*
Maternity			
Inpatient	100%	100%	70%
The hospital stay following a normal delivery may generally not be limited to less than 48 hours for both mother and newborn; and may not be limited to less than 96 hours following a Cesarean Section.			
Newborn Benefits			
Hospital Nursery	100%	100%	70%
Well Baby Care	$15 copay per office visit 100%	$15 copay per office visit 100%	Not covered out-of network
Mental Illness Benefits			
Inpatient	100% 20 days	$25 per day copay, 45 days (Combined)**	70% 45 days
Outpatient	$20 copay per office visit 20 visits per yr.	$15 copay per office visit 35 visits per yr. (Combined)**	70% 35 visits per yr.
Alcohol & Drug Abuse Benefits			
Inpatient	100%, 20 days	100%, $25 per day copay, 35 days (Combined)**	70% 35 days
Outpatient	$20 copay per office visit 20 visits per yr.	$15 copay per office visit 60 visits per yr. (Combined)*	70% 60 visits per yr.
Prescription Drug Benefits	HMOIL / BLAD	POS In-Network	POS Out-of-network*
Individual pays per prescription and per refill. (30 day supply)	$10 / $10 copay Generic	$10 copay Generic	70%

HEALTH MAINTENANCE ORGANIZATION PLANS SCHEDULE OF BENEFITS (CONT.)

	HMO IL / BLUE ADVANTAGE HMO	CIGNA NETWORK POS PLAN In-Network	Out-of-Network*
	HMO IL / BLAD	POS In-Network	POS Out-of-network*
	$20 / $15 copay preferred brand name	$20 copay preferred brand name	70%
	$35 / $30 copay Non-preferred brand name	$40 copay Non-preferred brand name	70%
Routine Services			
Physical Exams	$15 copay, 100%	$15 copay, 100%	Not Covered
Immunizations & Inoculations	100%	100%	Not Covered
Eye Exams	$15 copay, 100%	$15 copay, 100%	Not Covered
Eye Glass Discount	$75 allowance every 24 months	Not Covered	Not Covered
Hearing Exams	100%	100%	Not Covered
	(HEARING AIDS OR THE EXAMINATION FOR THE FITTING OF HEARING AIDS ARE NOT COVERED.)		
Allergy Test & Treatment	100%	100%	70%

(THE PLANS DO NOT ALWAYS COVER ALL PRESCRIPTIONS. CHECK THEIR BOOKLETS FOR DETAILS.)

*Subject to calendar year deductible (See Group Insurance Certificate for details.)
** Maximum number of days and visits applies to the continuation of in-network and out-of-network.

GENERAL LIMITATIONS AND EXCLUSIONS – OPEN ACCESS PLUS & HMO(S)

Note: Check your Group Insurance certificate or Official Plan Document for a detailed list of limitations and exclusions as they apply to their plans.

No payment will be made for expenses incurred by you or your dependents:

- For medical service provided before your insurance effective date;
- For occupational accidents or sickness covered by Worker's Compensation or any other program including Medicare;
- For charges in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For charges which the employee or dependent is not legally required to pay;
- For charges which would not have been made had insurance coverage not existed;
- For expenses which exceed reasonable and customary charges for the locality in which they are incurred;
- For unnecessary care or treatment;

- For expenses that are otherwise payable under the coordination of benefits provision;
- For expenses that are reimbursable through third party liability;
- For expenses in connection with cosmetic surgery (Cosmetic surgery is covered under certain situations. Refer to your plan's booklet for details.);
- For eyeglasses, hearing aids or examinations for prescription or fitting thereof (The HMO covers eye exams and eyeglasses. The POS covers eye exams. Refer to your plan's booklet for details.);
- Services received without a referral from the HMO primary physician (Does not apply to self referral to an obstetrician or the Open Access Plus).
- For dental treatment (Dental treatment is covered under certain situations. Refer to your plan's booklet for details);
- For charges in connection with custodial care, education or training; (refer to your plan's booklet for possible exceptions)
- For experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution—limited by Federal law to investigational use."
- For experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society.
- Not all prescriptions are covered; check with the plan in which you are enrolled.

Women's Health and Cancer Rights

The 1998 federal Women's Health and Cancer Rights Act requires all health plans to cover reconstructive surgery following a mastectomy. When a covered person receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the medical plan must cover:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce symmetrical appearance;
- prostheses and physical complications in all stages of mastectomy, including lymphedema.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absences. These requirements apply to medical and dental coverage for you and your dependents.

Continuation of Coverage

For leaves of less than 31 days, an employee may elect to continue coverage under the same conditions as if the employee had continued to work.

For military leaves of 31 days or more, an employee may elect to continue coverage for up to 24 months by paying the COBRA rate that is in effect at that time.

For additional information, please refer to Personnel Policy Guide, Military Leave Section.

Newborn and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Who Is Eligible

All employees and their dependents except dayworkers and summer employees are eligible to

enroll for medical coverage as of the first day of employment.

All retirees and their dependents who meet the retirement eligibility requirements are eligible. (Refer to the retiree medical section of this booklet for details.)

If both husband and wife are employees of Fermilab, one may elect to be covered as a dependent of the other for medical coverage, or both can elect to be covered as employees. Neither can be covered as both an employee and a dependent. Dependent children whose parents are both employees of Fermilab may be covered under one plan only.

Who Is An Eligible Dependent

Open Access Plus and Health Maintenance Organizations

- Your lawful spouse.
- Your unmarried child who is less than 19 years old.
- Your unmarried child who is less than 23 years old, primarily supported by you and enrolled in school as a full-time student.
- Your unmarried child who is mentally or physically incapable of earning a living may be continued beyond age 19, if 60 days before he or she reaches the age limit, you submit proof of the child's incapacity to the insurance carrier .Proof of the child's dependency may be required once a year.

It is your responsibility to notify Fermilab's Benefits Office when one of your dependents is no longer eligible for coverage. They may be eligible for continuation of coverage. (See section "Rights at Termination of Coverage.")

Definition of a Dependent Child

Open Access and POS

Child includes a child born of the employee, a child legally adopted by the employee and a stepchild of the employee living with the employee in a normal parent-child relationship.

HMO IL

See your HMO IL booklet for details.

Qualified Medical Child Support Order

If a qualified medical child support order is issued for your child, that child will be eligible for coverage as required by the order, and you will not be considered a late enrollee for dependent coverage. A qualified medical child support order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including community property law), or administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group plan and satisfies all the following:

- The order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;

- The order specifies your name and last known address, and child's name and last known address, except the name and address of an official of state or political subdivision may be substituted for the child's mailing address:

- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to determined;

- The order states the period to which it applies; and

- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The Qualified Medical Support Order may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the plan, except an order may require a plan to comply with state laws regarding child health care coverage.

Appeal Process

HMO

You may file an appeal by writing to the HMO or contacting Member services.

Non-Urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal within 15 days after receiving the required information.

You will be informed in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call, or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within five business days of the appeal determination. Your representative, (if any), your PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

Urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal and notify you by phone within 24 hours or no later than three calendar days-of the initial receipt of the clinical appeal request. You will be notified in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within two business days of the appeal determination. Your representative (if any), your PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

Non-Clinical Appeal

A non-clinical appeal concerns an adverse decision of an inquiry, complaint or action by the HMO, its employees, or its independent contractors that has not been resolved to your satisfaction. A non-clinical appeal relates to administrative health care services that include (but are not limited to) membership, access, claim payment, denial of benefits, out of area benefits and coordination of benefits with another health carrier.

To begin a Level I appeal, you must notify Member Services by telephone or in writing that you want to pursue a non-clinical appeal. The HMO will send you a written confirmation within 5 business days of receiving your request. If the appeal can be resolved with existing information, the HMO will inform you of its decision within 30 business days.

If additional information is needed from either you or your medical group/IPA, the HMO will request that it be provided within five business days. The appeal decision will be made within 30 business days. When the decision cannot be made within 30 business days, due to circumstances beyond the HMO's control, the HMO will inform you in writing of the delay. A decision will be made on or before the 45th business day of receiving the appeal.

If the appeal is denied, you will be notified that your case is being referred to a Level II review. You or a representative has the right to appear in person, via conference call or some other method. After receiving your Level II appeal, the HMO will notify you in writing at least five business days before the Level II Appeals Committee meets. You will receive the committee's decision in writing within five business days of the meeting and within 30 business days of beginning the Level II appeal process.

Cigna

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to Cigna at the

toll free number or address that appears on your identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, Cigna will respond in writing with a decision within 15 calendar days after they receive the appeal for a required pre service or concurrent care coverage determination (decision). Cigna will respond within 30 calendar days after receipt of an appeal for post service coverage determination. If more time or information is needed to make a determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services, or (b) your appeal involves non authorization of an admission or continuing inpatient hospital stay. Cigna's physician reviewer in consultation with the treating physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are unsatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process as required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decisions may not vote on the Committee. For appeals regarding Medical Necessity or clinical appropriateness, the Committee will consult with at least one physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals, we will acknowledge in writing that we have received your request and schedule a Committee review. For required pre-service and concurrent care coverage determinations, the Committee review will be completed with 15 calendar days. For post service claims, the committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days of the Committee meeting, and within the Committee review time frames indicated above if the committee does not approve the requested coverage.

You may request that the appeal process be expedited if (a) the time frames under this process would seriously jeopardize your life health or ability to regain maximum function or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services, or (b) your appeal involves non authorization of an admission or continuing inpatient hospital stay. Cigna's physician reviewer in consultation with the treating physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna Healthcare or any if its affiliates. A decision to use

this voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Individual Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions must apply. The reason for the denial must be based on Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by Cigna's physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by Cigna.

Enrollment

At the employee orientation meeting on your first day of employment you can elect to enroll yourself and your family in one of the medical plans.

If you fail to elect medical coverage for yourself or your family within 30 days from your first day of employment you will have to wait until the next open enrollment period. Under some circumstances, you may be able to enroll without waiting for an open enrollment period. (See section "Special Enrollment.")

Effective Date of Coverage

Your coverage and your family's coverage will be effective on the day you enroll, but no earlier than the day you and your family become eligible.

Dependent Enrollment

You have 30 days after you acquire a dependent to enroll that dependent in the plan. If you fail to do so, you will have to wait for the next open enrollment period.

Open Enrollment

Fermilab has an annual open enrollment in order for ***active employees*** to make changes in medical plan selections, enroll in a medical plan or add dependents to a medical plan. The annual open enrollment is held provided there is an approved alternate plan available. The open enrollment period lasts 10 working days.

Exceptions for Newborns

A dependent child born while you are insured for single coverage will become insured on the date of the child's birth. If you do not elect family coverage to insure your newborn within 31 days, coverage for that child will end on the 31st day. **No benefits for expenses incurred beyond the 31st day will be payable.**

Note: Even if you already have family coverage on the birth date of your newborn child, you still must notify the Benefits Office no later than 31 days from the child's birth so the Benefits Office can report your child as an eligible dependent.

Special Enrollment

You can enroll yourself and your dependents in a medical plan without waiting for an open enrollment period if:

- You decline Fermilab medical coverage because you have other medical coverage, then you lose the other coverage because you are no longer eligible, or because the employer failed to pay the required premium. **In such cases, you must enroll in a laboratory medical plan within 30 days after losing the other coverage.** You will have to provide proof that you had other coverage.
- You decline Fermilab medical coverage because you have COBRA coverage, then you complete your COBRA coverage period. **In such cases, you must complete your entire COBRA coverage period, and you must enroll in a laboratory medical plan within**

30 days after completing your COBRA coverage period. You will have to provide proof that you completed your COBRA coverage period.

- You decline Fermilab medical coverage and then a new dependent is added to your family due to marriage, birth, adoption or placement for adoption. **In such cases, you must enroll in a laboratory medical plan within 30 days after the marriage, birth, adoption or placement for adoption.** You will have to provide proof of the event.

COST

Plan	Monthly Cost Single Coverage	Monthly Cost Family Coverage
Cigna Open Access Plus	$59.94	$204.41
Cigna Network POS	$40.83	$165.30
Blue Cross & Blue Shield Blue Advantage	$44.31	$150.66
Blue Cross & Blue Shield HMO Illinois	$49.79	$169.28

The employee's cost is reviewed annually. .Any new rate is effective at the time of open enrollment.

COORDINATION OF BENEFITS (COB)

When you or one of your dependents are covered under more than one group medical plan, benefits from all plans will be coordinated up to 100% of eligible expenses. The Open Access Plus, POS, HMO IL, and Blue Advantage HMO use the following order of benefit determination:

Plans with no COB provisions are always primary.

The plan that covers the individual as an employee is primary. The plan that covers the individual as a dependent is secondary.

The plan that covers the individual as an active employee is primary. The plan that covers the individual as a retired employee is secondary. (This does not apply to retirees of URA/Fermilab. See section "Other Employment.")

The plan of the parent whose birthday falls earlier in the year is primary. For example, DOB of father is October, and DOB of mother is June. The mother's plan is primary, and the father's plan is secondary. (Year of birth is not taken into consideration.)

If parents are separated or divorced, the primary plan is that of the parent who has custody. If there is a court decree designating one parent as responsible for health care expenses, that parent's plan will be primary.

COORDINATION OF BENEFITS WITH MEDICARE ELIGIBLES

Active Employees & Dependents Age 65 and Over

If you continue working after age 65, you have the right to make one of the following elections:

- **Continue primary coverage under one of the Fermilab medical plans.** In this case the Fermilab plan will pay benefits first. If your claim is for services covered by Medicare, Medicare will pay second. You may receive from Medicare all or part of the unpaid balance of the claim, but not more than up to Medicare limits.
- **Elect primary coverage under Medicare:** In this case Medicare will pay your claims. There will be no benefits paid under any of Fermilab's medical plans.

The Benefits Office will assume that you want Fermilab's medical coverage as primary payer. If you want primary coverage under Medicare only, you must notify the Benefits Office and cancel your Fermilab medical coverage.

At least 2 months before your 65th birthday, you should notify the nearest Social Security Office and advise them that you are eligible to join Medicare Parts A & B. There is no charge to join Medicare Part A. The cost of Medicare Part B in 2006 is $88.50 per month.

You do not need to enroll in Medicare Part B until you retire from Fermilab. However, you must contact Medicare directly for their rules for when you may enroll in Part B, if you do not do so when first eligible, when planning your retirement date.

Disabled Employees and Disabled Dependents of Active Employees

Active employees who are no longer able to work because of a disability and who are eligible for Medicare must join Medicare Parts A & B. Medicare becomes the primary payer, and Fermilab's medical plan becomes the secondary payer. For disabled dependents of active employees, Fermilab's plan is the primary payer, and Medicare is the secondary payer. For those individuals eligible for Medicare because of end stage renal disease, Fermilab's medical plan is primary payer for only 18 months after that time period Medicare is the primary payer for bills related to the renal disability.

Retirees & Dependents 65 and Over

When you are eligible for Medicare Parts A & B, Medicare will be your primary payer, and Fermilab's plan will be the secondary payer. Benefits paid under the plan will be reduced by Medicare's payment. (It is important that you elect Medicare coverage because Fermilab's plan will not consider charges that Medicare could pay. Refer to the retiree section of this booklet for additional information.)

PLAN'S RIGHT TO REIMBURSEMENT

If you or your dependent receive benefits for covered expenses under one of the medical plans and subsequently collect payment for the same expenses from a third party by settlement, judgment or otherwise, you or your dependent must reimburse the appropriate plan for the amount of benefits received from the third party.

TERMINATION OF COVERAGE

Medical coverage terminates on the earliest of the following dates:

- The date the employee ceases to be in a class of eligible employees or ceases to qualify as an employee.
- The date the policy is discontinued.
- The date employment terminates.
- The date premium is not paid.

Rights at Termination of Coverage

You and your covered dependents are entitled to continue medical coverage in certain cases when coverage would otherwise terminate. These circumstances are described below.

Dependent Coverage in the Event of Your Death

If you should die while in ***active service***, your covered spouse and dependents may elect to continue on the same medical plan for 36 months. Under Federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), they can continue coverage for 36 months provided that they pay the cost for this coverage.

The cost to continue coverage for the first 12 months is the same family contribution rate the employee was paying at the time of death. (If the active employee deduction increases within that 12 month period, so will the cost to survivors up to the active employee deduction for family coverage.) The cost to continue coverage for the next 24 months is 102% of the full premium (laboratory and employee share.)

Under Illinois law if your covered spouse is 55 years old or older at the time of your death, your spouse can continue medical coverage until Medicare eligible (normally age 65) provided the spouse pays 150% of the full cost for this coverage, and is not covered by another group plan.

When group medical coverage terminates, your dependents may convert to an individual policy as described in the conversion section.

Coverage for Employees and Dependents Who Become Ineligible

ERISA provides that all plan participants shall be entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing your plan on the rules governing your COBRA continuation rights.

Consolidated Omnibus Budget Reconciliation Act (COBRA), enables you or your covered dependents to continue medical coverage under certain circumstances when coverage would otherwise terminate. Your or your covered dependents must pay the full cost of this coverage plus a 2% administrative fee.

You or your covered dependents may elect to continue medical coverage for 18 months if your coverage terminates because your employment terminates for any reason except gross misconduct. If you elect continuation of coverage for 18 months, you or your covered dependents may be able to extend COBRA coverage from 18 months to 29 months, if the Social Security Administration determines that you or a covered dependent was disabled before or within the first 60 days of COBRA continuation coverage. The coverage extension is available to the disabled individual and the individual's nondisabled family members who are entitled to COBRA continuation. Premiums during the additional 11 months of coverage will be at a substantially higher rate than for the initial 18-month period (150% of the current rate).

To qualify for the extension, you must notify Fermilab's Benefits Office in writing. In addition, you must submit a copy of the Social Security disability determination within 60 days of the date of the notice to Fermilab's Benefits Office.

Medical coverage may be continued by covered dependents for up to 36 months (up to 120 months in Illinois for spouses age 55 and over) if their coverage terminates because of one of the following events:

- your divorce or legal separation, or
- your child ceases to qualify.

The election form to continue medical coverage is given to you at your exit interview. Otherwise it is available from the Benefits Office, 15th floor Wilson Hall, extensions 4362 or 3395. You must elect continuation of coverage within 60 days of loss of coverage. From the date of election you have an additional 45 days to pay the required retroactive premium to avoid a gap in coverage.

If your covered dependents elect continuation coverage due to your termination of employment, they will be entitled to additional months of coverage (up to 36 months) if, during the first 18 months:

- you die,
- you divorce or legally separate,
- your child ceases to qualify as a dependent, or
- you become eligible for Medicare.

In order to be eligible for continuation of coverage, it is your or your dependent's responsibility to notify the Benefits Office when a dependent is no longer eligible for coverage. Notification and election to continue medical coverage must be given to the Benefits Office within 60 days from loss of eligibility.

Termination of COBRA Benefits

Continuation of coverage will stop before the end of the established time period if:

- you or your dependents become covered under any other group medical plan (as long as such group health plan does not contain any exclusion or limitation with respect to any pre-existing condition you or your dependents may have)
- you or your dependents become eligible for Medicare
- the required premiums are not paid within 30 days of the due date
- the plan is terminated
- you or your dependent is no longer disabled under the Social Security Act.

CONVERSION PRIVILEGE

At the end of your or your dependents' COBRA continuation period, you or your dependents may convert to an individual conversion policy. You may arrange for an individual conversion policy during the 180 day period before the COBRA period ends. The individual must apply in writing and pay the first premium within 31 days after the date group medical coverage terminates.

Individuals ineligible for COBRA benefits may be able to convert to an individual policy. (See details of the conversion privilege in your plan's certificate.)

CERTIFICATION OF GROUP MEDICAL PLAN COVERAGE

When your coverage terminates, you are entitled to receive documentation that certifies your Fermilab group coverage period. At your exit interview and at the end of your COBRA continuation period, you will receive a certification of group health plan coverage form detailing when you and your dependents were covered under Fermilab's medical plan. This certification form is also available upon written request.

EXTENDED BENEFITS AT TERMINATION OF COVERAGE

Preferred Provider Organization Plan

If you or a covered dependent is totally disabled at the time group coverage terminates, benefits will continue for up to 12 months after the date of termination without cost to you or your dependent for only the condition that caused total disability. If pregnancy exists on the date the Open Access Plus plan terminates, only the mother's maternity charges will be payable for that pregnancy.

To cover all other conditions and beyond the above time periods, see the section in this booklet titled "Rights At Termination of Coverage."

Point of Service and Health Maintenance Organization Plans

There are no free extended benefits for disabled individuals (including pregnancy) after the termination of group coverage. See the section in this booklet titled "Rights at Termination of Coverage."

LEAVE OF ABSENCE

If you are granted a leave of absence, you may continue your and your dependents' group medical coverage as long as you pay the full cost. You must notify the Benefits Office to make arrangements to continue the group medical coverage before your leave starts. Your group medical coverage will terminate at the start of your leave if you fail to elect continuation of coverage within 60 days from the start of your leave. If you elect coverage and you fail to return to from your leave, COBRA premiums will then apply.

If your request for a leave of absence meets the criteria for leave under the Family Medical Leave Act (FMLA), you may continue your and your dependent's group medical coverage as long as you pay the current employee deduction for such coverage. (See Fermilab's Personnel Policy Guide for details regarding FMLA.)

LAY OFF

Medical coverage ends on your last working day. If you are eligible for severance and if the runout payout option under the severance plan is an option available to you, your dental coverage will continue to the end of the payout period as long as you pay your portion of the premiums, and the plan is not terminated. COBRA continuation rules apply concurrently with severance runout period.

DISABLED EMPLOYEES

If you become totally disabled, and *you are receiving benefits under the Fermilab long term disability plan*, you and your eligible dependents will continue to be covered under the medical plan. Your coverage continues and your dependents' coverage continues if you continue to pay your portion of the required premium.

If, after two years of receiving Social Security disability benefits, you are still disabled, you must apply for Medicare benefits (Parts A & B) to supplement your group medical coverage. Fermilab's plan will assume that you enrolled in Medicare and will reduce the benefits accordingly when Medicare is the first payer.

A disabled employee who is eligible and elects to retire is treated as a retiree under the medical plan.

HOW TO FILE A CLAIM

Open Access Plus Plan

Claim forms are required for services received from out-of-network providers. The medical claim forms are available from the Benefits Office, 15th floor Wilson Hall, extensions 3395, 4362 or 4361. A claim form must be completed at least once a year per diagnosis. On the Claim Form there is a section to be completed by the employee and the patient (or patient's parent if the patient is a minor). The "Provider Section" on the claim form should be completed by the provider of services (e.g. doctor, hospital, pharmacist etc.) If the provider is unable to complete the Provider Section, you can attach the itemized bill to the claim form. Be sure that the diagnosis is on the provider's bill, and that you have copies of the claim form and bills for your records. Mail the claim form to the claims office address on the form.

The claim form should be completed as soon as you have incurred covered expenses. Claims will be honored up to two years after you have incurred them. Decisions on most claims submitted will be made within 30 days of submission. If the claim is denied, you will receive a written reason for the denial. When a claim is denied, you may have it reviewed by both a Fermilab representative and a Connecticut General claims representative. Determinations will be made in writing within a reasonable period.

Point of Service Plan and HMO Illinois

Claim forms are not required for services received from your primary care doctor. All referrals made by your primary care doctor must be made in writing. If you receive referral bills, contact your plan for instructions.

If you receive out-of-area emergency treatment, you must submit the bills to your plan for payment. You may have to complete a claim form. Contact your plan for instructions.

RETIREE MEDICAL PROGRAM

Who is Eligible for Retiree Medical Benefits

Starting at age 55 a combination of age and continuous years of service (3 year minimum) must equal 65 before employees and their eligible dependents are eligible for retiree medical benefits. (For example an employee with ten unbroken years of service would be eligible for retiree medical benefits at age 55; with five years of service at age 60.)

Who is an Eligible Dependent

Your lawful spouse and eligible children enrolled in the medical program at least for three continuous years immediately prior to retirement are eligible to participate in the retiree medical program. (If an employee's spouse was covered at least for three years under another employer's medical plan and not Fermilab's plan immediately prior to the employee's retirement date, that dependent is considered eligible to participate in the retiree medical program. Proof of spouse's other coverage is required at retirement to enroll in the Open Access Plus or HMO IL plan. There are no retiree benefits under the Point of Service Plan.

Dependent Coverage in the Event of Your Death

Dependent retiree medical benefits will continue for your spouse in the event of your death.

Benefits

Preferred Provider Organization

The Open Access Plus retiree medical plan is the same as the active employee Open Access Plus medical plan. However, at age 65 the plan is designed to supplement Medicare Parts A & B to the level of coverage provided to active employees.

Health Maintenance Organization (HMO IL)

The under age 65 HMO retiree medical benefits are the same as the active employee HMO medical benefits. However, at age 65 the HMO benefits are designed to supplement Medicare Parts A & B, and the benefits may vary from the active employee HMO medical benefits. (Refer to your HMO booklet for details.)

Medicare

When you or your dependent become eligible for Medicare at age 65, you *must* join Medicare Parts A & B. Medicare will be the first payer and Fermilab's plan will be the second payer. There is a substantial reduction in Open Access Plus and HMO medical benefits if you fail to join both parts of Medicare. The Open Access Plus and the HMO will not pay for medical expenses that Medicare could be paying.

Enrollment

At least two months before you retire make an appointment with the Benefits Office, extension 4361 to complete a Retirement Application. If you are eligible for retiree medical coverage and are enrolled in HMO IL prior to retirement, you can elect to remain in HMO IL or transfer your coverage to the Open Access Plus plan. **This is a one-time option. The annual "open enrollment" does not apply to retirees.**

Cost

Employees who retire on or after January 1, 1997 must contribute to the cost of their coverage. The rate retirees contribute for their medical insurance premium was stated on their Fermilab Retirement Application and Summary of Retiree Benefits Memo. Effective January 1, 2002, all employees subsequently selecting early retirement will continue to pay the premium amount agreed upon for active employees following the annual group insurance review. All employees who are 65 years or older and are eligible for Medical coverage and elect the coverage will pay the difference between the annual rate for active employees and the Medicare premium if it exceeds the prevailing Medicare premium. The minimum premium that Medicare eligible retirees will pay for single coverage is $2.50 and for family coverage is $5.34. Premiums for Medicare eligible retirees will be reconsidered every January.

Example: Retiree Monthly Payments

	Active Rate	**Retiree Under Age 65**	**Retiree Age 65 & Over***
Open Access Plus			
Single	$59.94	$59.94	$2.50
Family	$204.41	$204.41	$27.41**
Family	$204.41	N/A	$115.91***
HMOIL			
Single	$49.79	$49.79	$2.50
Family	$169.28	$169.28	$5.34**
Family	$169.28	N/A	$80.78***

*Medicare rate: $88.50 per individual 2006
**Retiree and spouse both on Medicare
*** One spouse on Medicare and one spouse non-Medicare

Termination of Coverage

Medical coverage terminates on the earliest of the following dates:

- The date the plan is discontinued.
- The date premium, if applicable, is not paid.
- The date the retiree ceases to be eligible because of other employment.
- The date the retiree cancels coverage. (Retiree coverage that is declined or cancelled, other than for other coverage, can not be reinstated.)

Other Employment

If an employee retires and becomes re-employed, the retiree will be excluded from Fermilab's retiree medical program if the new employer makes available group medical coverage. Retiree medical coverage can be reinstated upon termination of the other employment. However, reinstatement may not always be the same medical plan in which you were enrolled prior to your other employment. You must notify the Benefits Office within 30 days of termination of the other

employment to reinstate Fermilab retiree medical coverage.

How to File a Retiree Medical Claim

Preferred Provider Organization

Retirees & Dependents Under Age 65

Claims are filed exactly the way they were filed when you were an active employee enrolled in the Open Access Plus plan. (See section "How to File a Claim.")

Retirees & Dependents Age 65 and Over

Medicare is your first payer. All claims should be submitted to Medicare first. When you receive the Medicare payment voucher or denial, attach a completed Open Access Plus claim form and itemized bill to it, and forward the claim to the claims office address on the form. Failure to follow this procedure will delay processing of your claim.

Health Maintenance Organization (HMO IL)

Claim forms are not required for services received from your primary care doctor. All referrals made by your primary care doctor must be made in writing. If you receive referral bills, contact your HMO for instructions. If you receive out-of-area emergency treatment, you must submit the bills to the HMO for payment. You may have to complete a claim form. Contact your HMO for instructions.

GRIEVANCE PROCEDURES – ACTIVE AND RETIRED EMPLOYEES

Following is a brief description of each of the plan's grievance procedures. Refer to your plan's booklet for details. Failure to follow the correct procedure within the time allowed will jeopardize your claim.

All complaints can also be directed to the:

Illinois Insurance Department
Consumer Services Section
320 West Washington
Springfield, Illinois 61767

Preferred Provider Organization

The procedure is described in the ERISA Information Section of this booklet.

CIGNA Point of Service Plan

All inquires and complaints should be directed to:

Member Relations Department
CIGNA Healthplan of Illinois
1700 Higgins Road
Des Plaines, Illinois 60018
630-699-5671

HMO Illinois / Blue Advantage

Should HMO Illinois deny your claim, you may have your claim reviewed by writing to:

Director
HMO Illinois / Blue Advantage
233 North Michigan Avenue, Suite 1625
Chicago, Illinois 60601

ERISA INFORMATION

This section contains a summary description of the following medical plans:

Plan Name	Plan Number
CIGNA Open Access Plus	502
HMO Illinois	509
CIGNA Network POS	512

Employer Identification Number

52-0816670

Plan Sponsor

Universities Research Association, Inc.
(Fermi National Accelerator Laboratory)
P.O. Box 500
Batavia, Illinois 60510

Type of Plan

Welfare – Medical

Plan Year Ends
The benefit plan records are kept on a calendar year basis. The plan year ends each December 31.

Plan Administrator
Head, Laboratory Services
Fermi National Accelerator Laboratory
P.O. Box 500
Batavia, IL 60510
(630) 840-3396

Plan Fiduciary
Vice President
Universities Research Association, Inc.
Suite 400
1111 19th St. N.W.
Washington, D.C. 20036

Agent for Service of Legal Process
Plan Administrator and/or Plan Fiduciary

Plan Cost
Paid by the employer and employee.

Benefits Provided and Administered by
Connecticut General Life Insurance Company
195 Broadway
New York, NY 10007

HMO Illinois, Inc.
1515 West 22nd Street
Oak Brook, IL 60521-0226

CIGNA Healthplan of Illinois, Inc.
1700 Higgins Road, Suite 600
Des Plaines, IL 60018

Effective Date

Medical Insurance	08/01/67
HMO Illinois	01/01/85
CIGNA Health Plan	10/01/87
Blue Advantage Plan	10/01/04

Eligibility
All employees and their eligible dependents except dayworkers and summer employees. All retirees and their eligible dependents.

Loss of Benefits
You and your eligible dependents must continue to be a member of an eligible class and continue to make any required contributions. (See termination of coverage section.)

Universities Research Association, Inc. (Fermi National Accelerator Laboratory) maintains the right through the plan administrator to modify, amend or terminate the medical plans described in this booklet.

Collective Bargaining Agreements
Benefit information can be found in the following labor agreements.

- Local No. 701, International Association of Machinists (AFL-CIO): Machinist and Welders.
- Local No. I-21, International Association of Fire Fighters (AFL-CIO): Fire Fighters.
- Local No. 701, International Association of Machinists (AFL-CIO): Computer Operators.
- Local No. 701, International Association of Machinists (AFL-CIO): Electricians and Mechanics.
- Local No. 701, International Association of Machinists (AFL-CIO): Truck and Taxi Drivers.

Requests for Information and Claim Procedures
Requests for information and claims concerning eligibility, participation, contributions, or other aspect of the operation of any plan should be directed to the Plan Administrator. If a written request or claim is denied, the Administrator shall, within a reasonable time, provide a written denial to the participant. It will include the specific reasons for denial, the provisions of the plan upon which the denial is based, a description of any material needed to complete the claim (if appropriate) and why it is necessary, and instructions on how to apply for a review of the claim. When the Administrator requires additional

time to process a claim because of special circumstances, an extension may be obtained by notifying the participant that a decision on the claim will be delayed, what circumstances have caused the delay and when a decision can be expected. The Administrator will inform the participant of the delay within ninety days of the date the claim was submitted.

A participant may request in writing a review of a denied claim and may review pertinent documents and submit issues and comments in writing to the Administrator. The Administrator shall provide in writing to the participant a decision upon such request for review of a denied claim within sixty days of receipt of the request. When special circumstances require an extension, the Administrator may obtain such extension by notifying the participant that the decision on the review of the denied claim will be delayed, why and when a decision can be expected. See each plan's section for specifics on how to file a claim.

Rights and Protections

The following statement of ERISA rights is required by federal law and regulation. As a participant in the retirement and welfare plans you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's Office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreement and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The Plan Administrator's Office is located at Robert R. Wilson Hall, 15th floor.
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator.
3. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, you union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a pension or welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial. You have the right to have the claim reviewed and reconsidered.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within thirty days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension & Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the

Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210.